BRICKYARD
DENTAL CLINIC

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Dear Patient,

In accordance with CDSBC's Infection Prevention and Control Guidelines and BCDA's Exposure Control Plan, please indicate "YES" or "NO" to the following questions and sign and date below:

Do you have any of the following symptoms?

- **dry cough?** YES / NO
- **sore throat or painful swallowing?** YES / NO
- **shortness of breath?** YES / NO
- **fever?** YES / NO
- **runny nose, sneezing, post-nasal drip, loss of smell (anosmia) with or without fever?** YES / NO
- **loss of appetite?** YES / NO
- **chills?** YES / NO
- **muscle aches?** YES / NO
- **headache?** YES / NO
- **fatigue?** YES / NO

Have you travelled outside of Canada within the last 14 days? YES / NO

Have you had any close contact or have you been in isolation with a suspected case of COVID-19 in the last 14 days? YES /NO

Have you had any other potentially relevant exposure such as close contact with someone who was ill and/or had travelled outside of Canada within 14 days? YES /NO

Has there been any changes to your medical history? YES /NO
If you answered "YES", please provide details: _____

Print Name_____ Signature_____ Date_____
of Patient of Patient/Parent/Guardian